U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
ENFORCEMENT AND REMOVAL OPERATIONS
ICE HEALTH SERVICE CORPS

DENTAL SERVICES

IHSC Directive: 09-01
ERO Directive Number: 11825.2
Federal Enterprise Architecture Number: 306-112-002
Effective: 4 Mar 2016

By Order of the Acting Assistant Director
Stewart D. Smith, DHSc/s/

---

1. **PURPOSE:** The purpose of this issuance is to set forth the policy and procedures for the U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) scope of dental services and access processes in IHSC dental clinics. This includes dental clinic staffing, available services (initial, routine, urgent), and staff training.

2. **APPLICABILITY:** This directive applies to all IHSC personnel including but not limited to, Public Health Service (PHS) officers, civil service employees and contract personnel. It is applicable to IHSC personnel supporting health care operations in ICE-owned or contracted detention facilities and to IHSC Headquarters (HQ) staff. This directive applies to contract personnel when supporting IHSC in detention facilities and at HQ. Federal contractors are responsible for the management and discipline of their employees supporting IHSC.

3. **AUTHORITIES AND REFERENCES:**

   3-1. Title 8, Code of Federal Regulations, Section 235.3 (8 CFR § 235.3), Inadmissible Aliens and Expedited Removal.

   3-2 Section 232 of the Immigration and Nationality Act, as amended, Title 8, U.S. Code, Section 1222 (8 U.S.C. § 1222), Detention of Aliens for Physical and Mental Examination.

   3-3. Title 8, Code of Federal Regulations, Part 232 (8 CFR 232), Detention of Aliens for Physical and Mental Examination.

   3-4. Section 322 of the Public Health Service Act, as amended, Title 42 U.S. Code, Section 249(a) (42 U.S.C. § 249(a)), Medical Care and Treatment of Quarantined and Detained Persons.

3-5. Title 42, U.S. Code, Section 252 (42 U.S.C. § 252), Medical Examination of Aliens.

3-6. The Privacy Act of 1974, Title 5, U.S. Code, Section 552(a) (5 U.S.C. § 552(a)), as applied in the Department of Homeland Security (DHS) Privacy Policy Memorandum: 2007-1, "DHS Privacy Policy Regarding Collection, Use, Retention, and Dissemination of Information on Non-U.S. Persons," (January 7, 2009).

4. POLICY: Each detainee/resident, hereafter referred to as "detainee," with a documented need for dental services should have access to care and receive services consistent with professional standards. Off-site dental care services should be obtained when the required services cannot be provided at an IHSC dental clinic.

4-1. Dental Services. Dental health services provided to detainees include a dental screening at the time of physical examination, routine dental care, urgent care and education. Dental needs are identified through the intake screening process, health assessment, sick call requests and referrals identified through medical encounters and by ICE or security staff. These services include:

a. Dental Screening.

Adults: All adult detainees should receive a dental screening within 14 days of intake during the scheduled health assessment by a Registered Nurse, mid-level provider (MLP) or physician who has received the necessary dental training.

Minors: All minors should receive a dental screening within 7 days of intake during the scheduled health assessment by a Registered Nurse, MLP or physician who has received the necessary dental training.

b. Routine Dental Care.

Adults: Routine preventive dental care is provided regardless of multiple facility transfers and may begin after six months, but not later than 12 months of continuous ICE detention. Routine care needs are subordinate to urgent care needs. Routine care includes a comprehensive exam, necessary radiographs and a treatment plan for other routine services that can be provided as time and resources allow. Such routine services may include prophylaxis (e.g., cleanings), amalgam restorations, composite resin restorations (tooth-colored) and extractions. Root canals are only limited to front teeth (i.e., incisors and canines) and this procedure should be completed according to the

acuity of need. Additional treatment may be rendered in unusual circumstances, if sufficient caloric intake cannot be maintained.

Minors: An oral exam is completed by a licensed dentist within 60 days of admission but may be completed sooner if dictated by local state detention standards. Radiographs will be used when appropriate to develop a treatment plan and urgent needs will receive treatment priority. Routine care needs are subordinate to urgent care needs. Routine services may include prophylaxis, restorations, sealants, fluoride treatments, extractions and occasionally root canals on select teeth if deemed essential to maintaining a functional occlusion. Additional treatment may be rendered in unusual circumstances if sufficient caloric intake can not be maintained.

c. Urgent Care. Dentists, physicians, MLPs and registered nurses should provide acute dental intervention as needed. All detainees should receive urgent care facilitated through the sick call request process. Urgent care should be provided to the detainee to relieve pain, treat acute infection or help correct caloric intake.

d. Education. Medical and dental staff should provide oral hygiene and preventive oral education to detainees during the intake process. Additional education should be provided to the detainee, as needed, due to detainee pathology determined during treatment.

4-2. Off-Site Dental Treatment and Diagnostic Services. The dentist or medical provider should initiate an off-site dental services referral when the IHSC dental clinic cannot provide the required treatment, or when the dental condition of a detainee does not stabilize with on-site dental treatment.

a. Medical or dental staff should assess detainees who receive off-site dental care upon their return. If the detainee returns after normal business hours, medical or dental staff should assess the detainee the next business day.

4-3. Consent for Dental Treatment. If a consent for treatment form was completed during the intake process, written consent for routine treatment is not required.

a. A dental provider must complete the appropriate dental consent form for all invasive dental treatment services (For specific procedures, *See 4-6. Documentation and Records Management*). In the case of minors, the informed consent of a parent, guardian or a legal custodian is necessary. The dental provider should make an annotation in the health record that a "Time-Out" was conducted prior to the initiation of

the services. This ensures understanding of planned procedures consented to by the patient or guardian before procedures are performed by dental staff.

b. Time Out : After the proposed procedure is explained to the patient in a language they understand, the dental clinic personnel will ask the patient to point to the teeth/surgical sites in question and verbalize what procedure they have consented to. Operator, assistant and patient must all agree prior to initiation of the planned procedure.

4-4. Dental Staffing. Dental staff is assigned based on the complexity of the local IHSC Medical Clinic as described in the *IHSC Dental Health Services Operations Manual.* Dental staff include dentists, dental assistants and registered dental hygienists.

4-5. Operations Manual. All IHSC-staffed dental clinics should abide by the *IHSC Dental Health Services Operations Manual.*

4-6. Documentation and Records Management. All dental health care encounters should be documented in the electronic health record (eHR)/ eClinical Works (eCW). The following IHSC dental forms should be used as described below:

a. Dental Exam Form (IHSC Form 900). This form is used to detail dental health during the comprehensive dental exam and the course of treatment based on urgent and deferred treatment needs. This form is used only as an alternative if the dental software is inaccessible.

b. Dental Endodontic Treatment Consent Form (IHSC Form 901). This form is used to document that the risks of initiating or completing endodontic treatment have been explained to the detainee.

c. Dental Periodontal Treatment Consent Form (IHSC Form 902). This form is used to document that the risks of periodontal treatment have been explained to the detainee. This form also verifies the detainee's understanding of their responsibility to practice good oral hygiene.

d. Oral Surgery Treatment Consent Form (IHSC Form 903). This form is used to document that the risks of the dental surgical procedure have been explained to the detainee. This form should be completed and explained to the detainee prior to any surgical procedure.

e. Dental Nitrous Oxide Sedation Consent Form (IHSC Form 904). This form is used to document that the risks of nitrous oxide sedation have been explained to the detainee.

f. Dental Medical History Form (IHSC Form 905). This form is used to document the health history of the detainee and is an essential part for all dental treatment(s).

g. Dental Treatment Record Form (IHSC Form 906). This form is used to document dental treatment performed on the detainee. This form should only be used as an alternative if eCW is inaccessible.

h. Dental Triage Assessment Form (IHSC Form 907). This form may be used for the initial evaluation of a detainee who requests dental services through the sick call process. This form should only be used if eCW is inaccessible.

i. Dental Restorative Consent Form (IHSC Form 908). This form is used to document that the risks of performing restorative procedures have been explained to the detainee.

j. Periodontal Charting Form (IHSC Form 909). This form may be used as an adjunct when necessary to document, screen and record the overall periodontal condition of the detainee. This form is used only as an alternative if the dental software is inaccessible.

k. IHSC Treatment, Authorization and Consultation Form (IHSC Form 812). This form may be utilized when seeking opinions about a detainee's health condition from other medical or dental practitioners. When an eHR record is used, the chart review process can be utilized in place of this form.

4-7. Dental Software. Dental treatment planning software should be used to document the detainee's overall dental health condition and develop a dental comprehensive treatment plan.

4-8. Detainee Identification. Detainee identification should be verified by at least two methods prior to a detainee receiving medications or dental care services. Identification measures include: the detainee identification wrist band, the detainee photo identification, asking the detainee to state his/her name, or using the detainee's alien registration number.

4-9. Equipment Maintenance. All equipment maintenance should be performed in accordance with the manufacturer specifications and per an established preventive maintenance schedule.. Documentation will be maintained by the local supervisory/lead dentist and additionally by the HSA.

4-10. Clinic Space, Equipment and Supplies: Sufficient space, supplies and equipment are available to support facility dental services and will minimally include the following basic equipment:

a) Hand washing facilities or appropriate alternate means of hand sanitization
b) Dental examination chair(s)
c) Examination light
d) Sterilizer
e) Instruments
f) Trash containers for biohazardous materials and sharps
g) A dentist's stool and assistant's stool if appropriate

If a dental operatory is established and invasive procedures are performed in the clinic additional minimal equipment requirements include the following:
1) An x-ray unit w/ digital functionality
2) Blood pressure monitoring equipment (if not immediately accessible in the medical clinic
3) Oxygen (if not immediately accessible in the medical clinic)

4-11. Emergency Medical Equipment. The dental department should be prepared to implement urgent medical care procedures. The choice of basic emergency equipment located in the dental clinic depends on its proximity to the units urgent care facilities, the distance from the nearest ER and the level of staff training but minimally will include blood pressure monitoring equipment and oxygen if not immediately accessible in the medical clinic.All dental staff should maintain Basic Life Support (BLS) certification.

4-12. Mercury Contamination. A Mercury Clean-up Kit should be maintained in each dental clinic and should be used in the event of mercury spills or contamination.

4-13. Responsibilities.

a. IHSC Chief Dentist. The IHSC Chief Dentist is responsible for providing guidance and direction for the national dental program.

b. Regional Dental Consultant. The Regional Dental Consultant (RDC) is responsible for assessment of referrals received from both dentists in the IHSC dental program and contracted dentists providing care to detainees through the Managed Care Medical Payment Authorization Request (MedPAR) system. The RDC also assists the IHSC Chief Dentist in providing guidance and support to the IHSC dental clinics.

c. Supervisory/ Lead Dentist.. The Supervisory /Lead Dentist is responsible for the management and delivery of services at the assigned clinic. At two dentist sites one dentist assumes the supervisory position, the other the staff dentist position.

d. Staff Dentist. The staff dentist is responsible for the provision of clinical services and other supportive duties as assigned.

e. Registered Dental Health Hygienist. The Registered Dental Hygienist (RDH) is responsible for the delivery of preventive care at the local IHSC medical clinic, under the guidance and charge of the local supervisory dentist.

(1) RDH Scope of Practice. Based on the proficiency demonstrated through direct observation, training and/or verbal confirmation of knowledge, the supervisory dentist will sign the scope of practice checklist, authorizing the RDH to function under these specific practice guidelines. Any condition or treatment modality not included in the authorized scope of practice must be referred to the appropriate dentist. This scope of practice must be renewed annually by the local supervisory/lead dentist and RDH and the health services administrator (HSA) should maintain the scope of practice document on-site.

(2) RDH Competencies. The Supervisory/Lead Dentist should complete a competency checklist for the RDH during orientation and on an annual basis. The HSA or designee is responsible for tracking and scheduling these competency assessments. The supervisory lead dentist should provide and document training for RDHs if deemed necessary. The HSA or designee should maintain competency checklists in the RDH's on-site personnel file.

f. Dental Assistants. Dental Assistants (DAs) are responsible for assisting the dentists and the RDH in the delivery of dental care at the facility's IHSC dental clinic and are responsible for appointment scheduling, data entry, maintenance of dental logs, instrument control and supply inventory.

(1) DA Scope of Practice. Based on the proficiency demonstrated through direct observation, training and/or verbal confirmation of knowledge, the supervisory and/or lead dentist will sign the scope of practice, authorizing the DA to function under these specific guidelines. This scope of practice must be renewed annually and the HSA or designee should maintain the scope of practice on-site.

(2) DA Competencies. The supervisory and/or lead dentist should complete a competency checklist for each DA during orientation and on an annual basis. The HSA or designee is responsible for

tracking and scheduling these competency assessments. The supervisory and/or lead dentist should provide and document training for DAs if deemed necessary. The HSA or designee should maintain competency checklists in the DA's on-site personnel file.

4-14. Dental Health Training. A licensed dentist should provide initial and annual dental health training to all IHSC health care providers. The training content should be based on the staff function within the organization.

a. Dental Health Training for all IHSC medical staff includes:

(1) Detection of suspected oral pathology and referral;

(2) Recognition of emergent versus non-emergent dental needs;

(3) Other topics as directed by ICE.

b. Dental Health Training for Medical Providers. All IHSC medical providers should receive training related to recognition of dental pathology and its sequelae, including:

(1) Soft tissue oral pathology;

(2) Suggestions for management of dental infections (ranging from minor to severe);

(3) Pulpal and Periodontal conditions;

(4) Trauma; and

(5) Oral Screening Instructions

(6) Other training as required.

c. Training for Dental Staff. All dental staff receive training to include, but not limited to:

(1) General orientation;

(2) Tool control;

(3) Infection control;

(4) Continuing education; and

(5) Specialized training.

5. PROCEDURES: None.

6. HISTORICAL NOTES: This directive Replaces directive 09-01 Dental Services, dated 4 Dec 2015. It makes changes in sections 4-9 through 4-13.

7. DEFINITIONS: See definitions for this policy in the IHSC Glossary located on SharePoint.

8. APPLICABLE STANDARDS:

8-1. Performance-Based National Detention Standards (PBNDS):

PBNDS 2011: 4.3 Medical Care.

8-2. American Correctional Association (ACA):

-Performance-Based Adult Local Detention Facilities

4-ALDF-4C-03: Clinical Services

4-ALDF-4C-08: Emergency Plan

4-ALDF-4C-18: Sterilization/Waste Management

4-ALDF-4C-20: Dental Care

4-ALDF-4C-21: Health Education

4-ALDF-4C-22: Health Screenings

4-ALDF-4C-35: Prostheses

4-ALDF-4D-15: Informed Consent

4-ALDF-4D-25: Peer Review

-Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions

1-HC-1A-03: Clinical Services/Sick Call

1-HC-1A-05: Referrals

1-HC-1A-08: Emergency Plan/Access to Care

1-HC-1A-15: Sterilization

1-HC-1A-17: Dental Care

1-HC-1A-18: Health Education

1-HC-1A-20: Health Screenings

1-HC-1A-32: Prostheses

1-HC-3A-04: Informed Consent

1-HC-4A-04: Peer Review

8-3. National Commission on Correctional Health Care (NCCHC):

Standards for Health Services in Jails, 2014:

J-E-04: Initial health Assessment

J-E-06: Oral Care

J-E-08: Emergency Services

J-E-07: Nonemergency Health Care Requests

J-C-09: Orientation for Health Staff.

J-D-03: Clinical Space,Equipment, and Supplies

Y-E-06: Juvenile Care and Treatment

9. PRIVACY AND RECORDKEEPING. IHSC maintains detainee health records in accordance with the Privacy Act and as provided in the Department of Homeland Security (DHS)/ICE-013 Alien Health Records System of Records Notice, 80 Federal Register 239 (January 5, 2015). The records in the eHR/eCW are destroyed ten (10) years from the date the detainee leaves ICE custody. Retention periods for records of minors may differ. Paper records are scanned into the eHR and are destroyed after upload is complete.

ICE maintains individual detention and removal records in accordance with the Privacy Act and as provided in the DHS/ICE-011 Immigration and Enforcement

Operational Records System of Records (ENFORCE), 80 Federal Register 24269 (April 30, 2015).

Protection of Medical Records and Sensitive Personally Identifiable Information (PII).

9-1. Staff must keep all health records, whether electronic or paper, secure with access limited only to those with a need to know. Staff should lock paper records in a secure cabinet or room when not in use or not otherwise under the control of a person with a need to know.

9-2. Staff should be trained at orientation and annually on the protection of patient medical information and Sensitive PII.

9-3. Staff should reference the Department of Homeland Security *Handbook for Safeguarding Sensitive Personally Identifiable Information* (March 2012) at:

(b)(7)(E)

when additional information concerning safeguarding Sensitive PII is needed.

9-4. Only authorized individuals with a need to know should be permitted access to medical records and Sensitive PII.

10. NO PRIVATE RIGHT STATEMENT. This directive is an internal policy statement of IHSC. It is not intended to, and does not create any rights, privileges, or benefits, substantive or procedural, enforceable against the United States; its departments, agencies, or other entities; its officers or employees; or any other person.